

ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD  
1740 W. ADAMS ST., SUITE 4600, PHOENIX, ARIZONA 85007  
PHONE (602) 364-1PET (1738) FAX (602) 364-1039  
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MAR 29 2019

BY:

COMPLAINT INVESTIGATION FORM

If there is an issue with more than one veterinarian please file a separate Complaint Investigation Form for each veterinarian

PLEASE PRINT OR TYPE

**FOR OFFICE USE ONLY**

Date Received: March 29, 2019 Case Number: 19-65

**A. THIS COMPLAINT IS FILED AGAINST THE FOLLOWING:**

Name of Veterinarian/CVT: Mary Eubank  
Premise Name: Casa Grande Animal Hospital  
Premise Address: 1645 N. Pinal Avenue  
City: Casa Grande State: Az Zip Code: 85122  
Telephone: 520-836-5979

**B. INFORMATION REGARDING THE INDIVIDUAL FILING COMPLAINT\*:**

Name: Margaret E. Mander  
Address: [REDACTED]  
City: [REDACTED] State: [REDACTED] Zip Code: [REDACTED]  
Home Telephone: [REDACTED] Cell Telephone: [REDACTED]

\*STATE LAW REQUIRES WE HAVE TO DISCLOSE YOUR NAME UNLESS WE CAN SHOW THAT DISCLOSURE WILL RESULT IN SUBSTANTIAL HARM TO YOU, SOMEONE ELSE OR THE PUBLIC PER A.R.S. § 41-1010. IF YOU HAVE REASON TO BELIEVE THAT SUBSTANTIAL HARM WILL RESULT IN DISCLOSURE OF YOUR NAME PLEASE PROVIDE COPIES OF RESTRAINING ORDERS OR OTHER DOCUMENTATION.

**C. PATIENT INFORMATION (1):**

Name: Stormy  
Breed/Species: Tabby  
Age: 2 years Sex: Male Color: Grey

**PATIENT INFORMATION (2):**

Name: \_\_\_\_\_  
Breed/Species: \_\_\_\_\_  
Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Color: \_\_\_\_\_

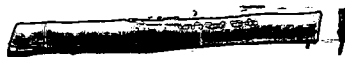

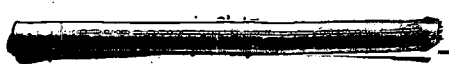
**D. VETERINARIANS WHO HAVE PROVIDED CARE TO THIS PET FOR THIS ISSUE:**

Please provide the name, address and phone number for each veterinarian.

- |                  |              |                                  |
|------------------|--------------|----------------------------------|
| 1. Eubank, Emily | 520-836-5979 | } Casa Grande<br>Animal Hospital |
| 2. Amber (Tech)  | 520-836-5979 |                                  |
| 3. AVECC (Vet)   | 480-497-0222 |                                  |
- } AVECC  
86 W. Juniper Ave.  
Gilbert, Az. 85233

**E. WITNESS INFORMATION:**

Please provide the name, address and phone number of each witness that has direct knowledge regarding this case.

- |                  |  |
|------------------|--|
| 1. Eubank, Emily |  |
| 2. Amber, Tech   |  |
| 3. AVECC (Vet)   |  |

**Attestation of Person Requesting Investigation**

By signing this form, I declare that the information contained herein is true and accurate to the best of my knowledge. Further, I authorize the release of any and all medical records or information necessary to complete the investigation of this case.

Signature: Margaret E. Mander

Date: March 23, 2019

**F. ALLEGATIONS and/or CONCERNS:**

Please provide all information that you feel is relevant to the complaint. This portion must be either typewritten or clearly printed in ink. ~~Unprofessional Behavior and lack of follow-up, advice & diagnosis of our cat Stormy.~~

After spending time trying to resolve this situation I was advised to contact your organization. These are the events in order of sequence. It's been 2 weeks and our family has really been traumatized by this. ~~###~~

3/10/19

On 3/10/19 about 2 p.m. I called the Vet because my cat wasn't eating or drinking water and I needed advice. The Vet was busy & the receptionist didn't know so I brought him in, there was blood in his urine when I picked him up. The Tech spent most of the time w/us but the Vet said it was a UTI and prescribed Antibiotics. She also suggested an x-ray, which he had & to <sup>(but did not elaborate)</sup> hydrate him. It was not deemed "very urgent", she left in 10 min. I went home & the cat remained the same. The antibiotics were labeled "For Dogs Only" as was the Bottle. I asked about it to another Vet & <sup>because this one was busy</sup> she said call yours. In the evening I gave him his second (1<sup>st</sup> was given at the Vet) dose.

I gave him water through a dropper. I was worried and anxious all night & called my sons who said I should just go back tomorrow.

3/11/19

In the morning, about 6:30 a.m., he was not much better, barely crawling along but drinking water. I went to work & rushed home <sup>at 4:30 pm</sup> and gave him Anti-Biotic dose and then he tried water and soft food. He threw it all up! I called the Vet (who was busy) & asked if I should give him another dose. In about 2 1/2 hours, she (receptionist) called back & said to skip it (wait until the morning). I continued to give him tho through a dropper most of the night. No other

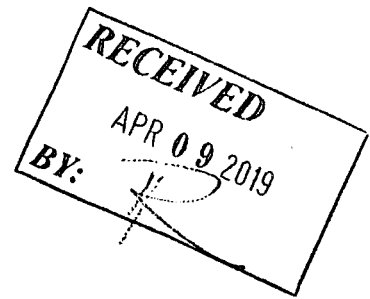
3/12/19

About 5:30 - 6:00 a.m. I woke up to go to work & give the cat Stormy his medicine. She was barely moving at this point and started to meow! I called the Casa Grande Vet <sup>and left a message</sup> (it was closed) so called AVECC in Gilbert (open) and rushed there. The cat was weak but still breathing fine. I was crying non stop & felt useless & helpless. I still do over this dilemma (that could have been prevented.) When I arrived about 7:45 - 8:00 a.m. at AVECC the Vet pronounced him dead! They were kind and compassionate & let me leave him there for the day. In the short time I was at AVECC (less than an hour) more concern, professionalism & knowledge about Animals was shown compared to the 3 days w/ Casa Grande Hospital. I had to go to work and upon my arrival was suspended for 5 days for texting (instead of calling in) even though I explained the situation. I teach children all day so it was tough & In just I felt that evening, with dead Stormy awaiting burial (next to my Dad's) I went to the C.G. Vet. & left a message for Vet to call me. She didn't.

3/13/19 That morning, about 9:40 a.m., <sup>(C.G. Grande Vet)</sup> Eubank left me a voice message about "concerns with your cat". I called her back and spoke for 7 min (non-stop), she never said a word except "Am sorry to hear that" no apologies, no remorse, almost mocking me & laughing on the phone (as if it was an afterthought). I contacted her Monday, she replied Wed After the cat died. I have not spoken to her since, I cannot

April 5, 2019

Arizona State Veterinary Medical Examining Board  
1740 West Adams Street, Suite 4600  
Phoenix, Arizona 85007



Case 19-65 (Mary Emily Eubank, DVM)

To Whom It May Concern:

On March 10, 2019, "Stormy Cat" presented to Casa Grande Animal Hospital. The owner reported that Stormy Cat had not been eating and had been bleeding from the perineal region.

Upon examination, the patient was bright, alert and responsive, with a moderately distended palpable urinary bladder, and was dribbling what was determined to be red colored urine onto the examination table in small quantities.

After discussing with the owner that male neutered cats are overrepresented with inflammatory urinary tract disease, and describing how his symptoms may potentially line up with FLUTD and/or a UTI, I recommended that we collect urine via ultrasound guided cystocentesis to assess for potential bladder stones with the ultrasound, and also collect a sterile urine sample for analysis.

I discussed with the owner the importance of fluid therapy in patients with urinary tract disease, and how fluid diuresis is necessary for treatment of cats with ongoing urinary conditions to allow the bladder and urethra to heal. The client specifically asked if fluids were "required". In response, I explained that, as a veterinarian, I could not "require" any specific treatment and that it is up to the owner to accept or reject any treatment recommendations. That being said, I did tell the owner in this case that I STRONGLY recommend fluids. The owner verbally declined fluids and I responded by telling her that we would be including subcutaneous fluids on a treatment plan estimate anyway.

A preliminary estimate was provided to the owner, including the examination, submitting a urinalysis to IDEXX for analysis, subcutaneous fluids, and oral amoxicillin medication to go home with the patient. As set forth in her statement, Amber Flores, my assistant, reviewed the estimate with the owner. The owner declined subcutaneous fluids, initialing the preliminary estimate as such. The owner agreed to the remainder of the treatment plan including the examination, urinalysis, and oral amoxicillin, signing the preliminary estimate with these treatments included.

The patient was brought to the hospital treatment area, ultrasound guided cystocentesis was performed, and urine was collected to submit to IDEXX. The urine collected was hemorrhagic. The patient's bladder was easily, non-painfully, manually expressed.

Upon returning the patient to the owner in the examination room, the owner advised the assistant that she did not want to submit the urine for urinalysis due to financial concerns. As a result, the urine was never submitted to IDEXX.

The patient was discharged with amoxicillin drops (50mg/mL) 30mL bottle. The instructions were 1.5mL by mouth orally every 12 hours until gone. The first dose was given by the assistant in the examination room and demonstrated to the owner.

At discharge, I personally discussed with the owner the grossly hemorrhagic findings of the urine collection, and likelihood of this to continue, or be a repeated condition without appropriate treatment. I also described specific symptoms to look for including straining to urinate, inability to urinate, frequently visiting the litter box, anorexia, lethargy, crying while urinating etc. The owner was advised to bring the patient back if any of these symptoms occurred, and a refrigerator magnet with emergency contact information for Arizona Veterinary Emergency and Critical Care Center was provided to the owner in the event Casa Grande Animal Hospital was closed or unable to be contacted in the event of an emergency.

Two days later, on March 12, 2019, the receptionist placed the record of the patient on my desk with a note indicating that the owner had stopped by and wanted me to call her. I then called the two numbers listed as the contact numbers on the owner's contact information sheet in the record. Specifically, I called the primary number at 3pm, then again at 5pm, and only got a busy tone. I called the secondary phone number at 8:10pm with no answer and no voicemail box.

The following day, March 13, 2019, I reread the note that had been left for me to call the owner and saw that the note had a phone number that was different than the two contact numbers that I had called the day before. As a result, I called the requested number, got no answer and left a message for the owner to call me.

The owner returned my call, and immediately began berating me regarding her cat's death. I allowed her to voice her concerns without interruption, saying when she paused toward the end that I was sorry this had happened and was sorry for her loss. Before I was able to say anything else, the owner informed me she would be getting a lawyer and hung up the phone. This was the last contact I had with her. Thank you.



Mary Emily Eubank, DVM



**ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD**

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PHONE (602) 364-1-PET (1738) ♦ FAX (602) 364-1039

VETBOARD.AZ.GOV

**INVESTIGATIVE COMMITTEE REPORT**

**TO:** Arizona State Veterinary Medical Examining Board

**FROM:** AM Investigative Committee: Robert Kritsberg, DVM - Chair  
Christina Tran, DVM  
Carolyn Ratajack  
Jarrod Butler, DVM - **Absent**

**STAFF PRESENT:** Tracy A. Riendeau, CVT – Investigations  
Dawn Halbrook, Compliance Specialist  
Sunita Krishna, Assistant Attorney General

**RE:** Case: 19-65  
Complainant(s): Margaret Mander  
Respondent(s): Mary Eubank, D.V.M. (License: 6935)

**SUMMARY:**

Complaint Received at Board Office: 3/29/19  
Committee Discussion: 6/11/19  
Board IIR: 8/21/19

**APPLICABLE STATUTES AND RULES:**

Laws as Amended August 2018  
(Lime Green); Rules as Revised September  
2013 (Yellow).

On March 10, 2019, "Stormy," a 2-year-old male domestic medium hair cat was presented to Respondent due to not eating and bleeding. It was determined the cat had a distended bladder and was dribbling bloody urine. Diagnostics and treatments were recommended; Complainant declined and elected to try antibiotics at home and would return if the cat did not improve.

On March 12, 2019, the cat passed away.

**Complainant was noticed and appeared.**

**Respondent was noticed and appeared telephonically. Attorney David Stoll was present.**

**The Committee reviewed medical records, testimony, and other documentation as described below:**

- Complainant(s) narrative: Margaret Mander
- Respondent(s) narrative/medical record: Mary Eubank, DVM
- Consulting Veterinarian(s) narrative/medical record: AVECCC

**PROPOSED 'FINDINGS of FACT':**

1. On March 10, 2019, the cat was presented to Respondent due to not eating and bleeding. Upon exam, the cat had a weight = 10.2 pounds, a temperature = 100.5 degrees, a heart rate = 180bpm and a respiration rate = 30rpm; BAR, BCS = 5/9. Respondent noted the cat had a distended urinary bladder and was dribbling bloody urine. She discussed with Complainant that male neutered cats are overrepresented with inflammatory urinary tract disease, and the cat's symptoms could be due to FLUTD (Feline Lower Urinary Tract Disease) and/or a UTI. Respondent recommended collecting urine via ultrasound guided cystocentesis to assess for potential bladder stones with the ultrasound, and collect a sterile urine sample for analysis.

2. According to Respondent, she discussed the importance of fluid therapy in patients with urinary tract disease and how fluid diuresis was necessary for treatment of cats with ongoing urinary conditions to allow the bladder and urethra to heal. Complainant asked if fluids were required; Respondent answered that as a veterinarian, she could not require any specific treatment and that it was up to the pet owner to accept or decline treatment recommendations. However, Complainant was advised that Respondent strongly recommended fluids. Complainant verbally declined.

3. An ultrasound guided cystocentesis was performed to collect urine to send out for testing. The urine was grossly hemorrhagic. Respondent expressed the urinary bladder manually.

4. According to Complainant, Respondent diagnosed the cat with a UTI and suggested an x-ray and hydrating the cat, which was not deemed urgent. It appears Complainant believes radiographs were performed on the cat.

5. An estimate was generated which included urinalysis to lab, SQ fluids and antibiotics. Complainant declined SQ fluids and advised technical staff, Ms. Amber Flores, that she could not afford the urine to be tested therefore the sample was not submitted for testing. Complainant relayed that she would try the antibiotic and if the cat did not respond she would return to collect another urine sample for testing. The cat was discharge with Amoxidrops.

6. The next day, Complainant did not see improvement in the cat – he was barely crawling; she administered the antibiotic and went to work. After work, Complainant gave the cat another dose of antibiotics – the cat drank some water and ate soft food, which he vomited. Complainant called Respondent's premise to ask if she should administer another dose of antibiotics since the cat vomited up the afternoon dose. Hospital staff later returned her call and advised not giving another antibiotic dose until the next morning.

7. On March 12, 2019, Complainant woke up to go to work and give the cat his antibiotic. The cat could barely move and was vocalizing. She called Respondent's premise and found that they were not open yet therefore she called an emergency facility. Complainant drove to the emergency facility and when she arrived the cat was pronounced deceased.

8. Complainant stopped by Respondent's premise and left a message for Respondent to call her. According to Respondent, she attempted to call Complainant twice at the phone numbers she had on file and only got a busy signal on the primary number and there was no answer or



voicemail on the second.

9. On March 13, 2019, Respondent noted that the number left by Complainant when she stopped by the premise was different than the phone numbers on file. She called the number and left a message for Complainant to call. Complainant returned her call and advised her of the cat's death and her concerns with Respondent's treatment of the cat.

#### **COMMITTEE DISCUSSION:**

The Committee discussed that the recommended diagnostics were documented in the medical record, explained and declined by Complainant. It is hard for a veterinarian to establish how serious a situation may be without being able to obtain information outside of an exam. A urine sample was collected however Complainant declined testing.

The Committee discussed that it is difficult to say how strong Respondent should have been with her recommendations for diagnostics after Complainant declined.

When the cat was not improving, Complainant could have taken him to an emergency facility; Respondent provided Complainant with emergency contact information if needed.

The Committee further discussed that the medication that was provided was appropriate for cats.

#### **COMMITTEE'S PROPOSED CONCLUSIONS of LAW:**

The Committee concluded that no violations of the *Veterinary Practice Act* occurred.

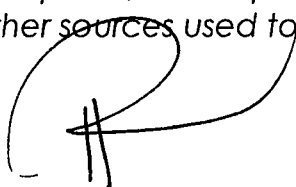
#### **COMMITTEE'S RECOMMENDED DISPOSITION:**

**Motion:** It was moved and seconded the Board:

*Dismiss this issue with no violation.*

**Vote:** The motion was approved with a vote of 3 to 0.

*The information contained in this report was obtained from the case file, which includes the complaint, the respondent's response, any consulting veterinarian or witness input, and any other sources used to gather information for the investigation.*




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Tracy A. Riendeau, CVT  
Investigative Division